STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DUM DDIG 00 COMP			ETED				
			A. BUILDING B. WING 11/12/2014			/2014			
			B. WIN	_	ADDRESS CITY STATE ZID CODE				
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE				
CROWNPOINTE OF CARMEL				11610 TECHNOLOGY DR CARMEL, IN 46032					
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
R000000									
	This visit was fo	or the Investigation of	R00	00000	Submission of this plan of				
	Complaint IN00	0158004.			correction does not constitute	_			
					admission or agreement by the provider of the truth of facts	е			
	Complaint IN00	1158004 Substantiated.			alleged or correction set forth	t forth on			
	_	related to the allegation			the statement of deficiencies.				
	is cited at R030	•			This plan of correction is				
	is cited at KU300	U.			prepared and submitted as a				
					requirement under state and				
	Survey Date: November 12, 2014 Facility number: 012309 Provider number: 012309 AIM number: NA				federal law. Please accept this	sas			
					our credible allegation of				
					compliance.				
	Survey Team: Mary Jane G. Fischer RN TC Census bed type: Residential: 31 Total: 31								
	Census payor ty	pe.							
	Other: 31 Total: 31 Sample: 3 This State finding is cited in accordance with 410 IAC 16.2-5.								
	Ovolite De in	was completed be-							
	Quality Review was completed by								
	Tammy Alley R	N on November 14,							
	l		<u> </u>		<u> </u>		l		
I A BOR A TOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATUR	E	TITLE		(X6) DATE		

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 5 State Form Event ID: EJ2T11 Facility ID: 012309 If continuation sheet

i '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED			
			B. WING		11/12/2014		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
				TECHNOLOGY DR			
CROWN	POINTE OF CARMI	EL	CARMEL, IN 46032				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	2014.						
R000306	410 IAC 16.2-5-6(a)(1-9)					
. 100000		ervices - Noncompliance					
		Iministered by the facility					
	•	in compliance with					
		II, state, and local laws,					
	•	any released, returned, or tion shall be documented					
	-	clinical record and shall					
	include the following						
	(1) The name of the						
		strength of the drug.					
	(3) The prescription						
	(4) The reason for(5) The amount dis	•					
	(6) The method of						
	(7) The date of the	•					
	(8) The signature	of the person conducting					
	the disposal of the	•					
		of a witness, if any, to the					
	disposal of the dru	review and interview the	R000306		11/13/2014		
			KUUUSUU	1.Resident A was not harme			
		ensure appropriate		The medication was destroyed			
		edications, in that when a		Two nurses destroyed the			
	resident had phy			medication and included the	hoir		
		rcotic medication, the		amount destroyed as well as t signatures on the narcotic cou	l l		
	•	ed to ensure a witness		record.	110		
		ruction in regard to the		2.All residents with orders to)		
		s remaining for 1 of 3		have a narcotic medication			
	sampled resident	's. (Resident "A").		discontinued have the potentia	al to		
				be affected. All nurses and			
				QMA's were re-educated on the	IE .		

State Form Event ID: EJ2T11 Facility ID: 012309 If continuation sheet Page 2 of 5

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY							
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	a. BUILDING 00		00	COMPLETED			
		B. WING 11/12/2014			11/12/2014				
		<u> </u>	P. "1"		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	PROVIDER OR SUPPLIER				ECHNOLOGY DR				
CROWNPOINTE OF CARMEL				CARMEL, IN 46032					
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
	`				CROSS-REFERENCED TO THE APPROPRIA	IE			
TAG		,		TAG	,	DATE			
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Findings include: The record for Resident "A" was reviewed on 11-12-14 at 11:00 a.m. Diagnoses included, but were not limited to, atrial fibrillation, high blood pressure, pain, osteoporosis and history of fall. These diagnoses remained current at the time of the record review. The nurses notes indicated the resident "states she fell at ECF [extended care facility] on Thanksgiving Day [2013] landing on right arm and has had increased pain since then." The resident was transported to the local area hospital Emergency Room for evaluation on 01-08-14. The Emergency Room documentation indicated the resident had a "possible rotator cuff tear," and the Emergency Room physician prescribed Norco (a controlled narcotic medication) 5 mg (milligrams) every 6 hours as needed for pain.			PREFIX TAG	GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) facility's policy on Medication Return and Destruction, (pleas see attachment A & B). 3. As a measure for ongoing compliance the DON or design will review drug destruction log to ensure required documenta is present weekly ongoing, (please see attachment C). 4. As a measure for quality assurance the DON or design will complete monitoring week ongoing. Should a deficient practice be noted, immediate corrective action will be taken. The plan of correction will be revised accordingly, as warranted. The Administrator monitor and sign off said monitoring on a monthly basis ongoing.	e DATE e e e e e e e e e e e e e e e e e e e			
	A physician order dated 04-29-14, instructed the nursing staff to discontinue the medication. A review of the "Drug Disposal Log," dated 04-29-14 indicated "reason - discontinued, method - flushed, amount - 20." This document only had one nurses signature and lacked a witness to the medication destruction or number of tablets destroyed.								

State Form Event ID: EJ2T11 Facility ID: 012309 If continuation sheet Page 3 of 5

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A HULLDING NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL ONLY SUMMARY STATEMENT OF DEPICIENCIES PREITY (LOCATI DEPICENCY MUST BE PRECIDED BY PLLI.) TAG PREITY TAG During an interview on 11-12-14 at 11:15 a.m., the Director of Nurses indicated that if the nurse received a Doctor's order to discontinue a narrotic, the medication remains on the cart until the nurse and destroy it. "The nurse destroys the medication with the QMA [Qualified Medication with the QMA [Qualified Medication with the Corporate Nurse Consultant indicated the facility policy "says the medication needs to be destroyed within 7 days of receiving the order." A review of the facility policy on 11-12-14 at 11:50 a.m., titled "Medication Return & Destruction," and undated, indicated the following: "Policy - Any medication that no longer has an active order shall be destroyed or returned based on procedures below as soon as possible, but no later than within 7 days of becoming inactive. Appropriate records of destruction or return shall be maintained in each resident's clinical record. Such medications include discontinued drugs,	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONS	TRUCTION	(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIES CROWNPOINTE OF CARMEL (YA) ID PREFIX TAG SIMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG During an interview on 11-12-14 at 11:15 a.m., the Director of Nurses indicated that if the nurse received a Doctor's order to discontinue a narcotic, the medication remains on the cart until the nurse can destroy it. "The nurse destroys the medication with the QMA [Qualified Medication Aide] present as the witness. They confirm the count and then they both sign this form [Drug Disposal Log]." During an additional interview on 11-12-14 at 11:30 a.m., the Corporate Nurse Consultant indicated the facility policy "says the medication needs to be destroyed within 7 days of receiving the order." A review of the facility policy on 11-12-14 at 11:50 a.m., tilted "Medication Return & Destruction," and undated, indicated the following: "Policy - Any medication that no longer has an active order shall be destroyed or returned based on procedures below as soon as possible, but no later than within 7 days of becoming inactive. Appropriate records of destruction or returns shall be maintained in each resident's clinical record. Such	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING 00 COMPLETED			ETED		
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL SIMMARY STATEMENT OF DEFICIENCIES						11/12/	2014	
CROWNPOINTE OF CARMEL INTO SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG During an interview on 11-12-14 at 11:15 a.m., the Director of Nurses indicated that if the nurse received a Doctor's order to discontinue a narcotic, the medication remains on the cart until the nurse and estroy it. "The nurse destroys the medication with the QMA [Qualified Medication Aide] present as the witness. They confirm the count and then they both sign this form [Drug Disposal Log]." During an additional interview on 11-12-14 at 11:30 a.m., the Corporate Nurse Consultant indicated the facility policy "says the medication needs to be destroyed within 7 days of receiving the order." A review of the facility policy on 11-12-14 at 11:50 a.m., titled "Medication Return & Destruction," and undated, indicated the following: "Policy - Any medication that no longer has an active order shall be destroyed or returned based on procedures below as soon as possible, but no later than within 7 days of becoming inactive. Appropriate records of destruction or return shall be maintained in each resident's climical record. Such		<u> </u>		EET ADD	ORESS CITY STATE ZIP CODE			
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medications increase discontinued drags,	TAG	During an interval.m., the Director that if the nurse order to discontinuedication remainurse can destroy the medication remainurse can destroy the medication of the witness. The then they both sit Disposal Log]. " During an additional three consultant policy is an additional to the stroyed within order." A review of the 11-12-14 at 11:5 "Medication Returned to the undated, indicated in the second as possible of the days of become Appropriate recorder turns shall be more resident's clinical terms."	iew on 11-12-14 at 11:15 or of Nurses indicated received a Doctor's nue a narcotic, the tins on the cart until the ty it. "The nurse dication with the QMA cation Aide] present as ey confirm the count and gn this form [Drug onal interview on 0 a.m., the Corporate at indicated the facility e medication needs to be a 7 days of receiving the facility policy on a.m., titled turn & Destruction," and ed the following: edication that no longer der shall be destroyed or on procedures below as but no later than within ing inactive. ords of destruction or naintained in each all record. Such	TAG		DEFICIENCY)		DATE

State Form Event ID: EJ2T11 Facility ID: 012309 If continuation sheet Page 4 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/19/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, DIIII D	n.c	00	COMPL	ETED			
		A. BUILD	ING		11/12/	/2014			
			B. WING	CTDEET A	DDRESS, CITY, STATE, ZIP CODE				
NAME OF P	PROVIDER OR SUPPLIEF	2							
CDOMANI		E!			ECHNOLOGY DR				
CROWN	POINTE OF CARM	EL		CARMEL, IN 46032					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	,	CY MUST BE PRECEDED BY FULL	PF	REFIX			COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	,	TAG	DEFICIENCY)		DATE		
	outdated drugs,	and drugs for residents							
	who are decease	d, or for resident who							
	have been discha	·							
	nave been disen	₅ -ca.							
	D 1	0							
		Once a resident is no							
	longer taking/using a medication, the								
	nurse must determine if the medication is								
	to be returned or destroyed 8. A drug								
	disposal log must be completed for the medications destroyed. If destroying a controlled substance, the quantity								
	_	orded in the Controlled							
	Drug Accountability Record as well as the drug disposal log. The destruction of controlled substance must be performed by a licensed personnel and a witness. 9. Oral solid dosage forms can be flushed down the toilet."								
	This State tag relates to Complaint IN00158004.								
				ļ					

State Form Event ID: EJ2T11 Facility ID: 012309 If continuation sheet Page 5 of 5